#### DOI FAOs -5/10/13

### **RATES**

## 1.) Rate Sample

Q: Please define or give details of what is required in the Rate Sample.

A: For the Rate Sample, carriers should submit the following information: 40 year old non-smoker rate for each metal tier - the richest and leanest plans, for each rating area, and for each product or Network sold in that area.

#### 2.) Rate Manual

Q: Is it sufficient to include rate tables within the actuarial memorandum, or does a separate "Rates Tables/Manual" need to be filed?

Carriers must file a separate Rate Tables/Manual.

- Q: On the last page (42) of the Filing Procedures for Colorado document, it states that a separate Rating Manual must be submitted for each product.
  - a. Is that "Product" the same definition as the HIOS product ID?

Yes, a Rating Manual should be submitted for each product.

## 3.) Act Memo

Q: For the actuarial memorandum, is there a final version of the excel file? Will it be acceptable if we create a pdf in the same format as appendix D in the filing procedures and then have all required exhibits in a supplemental excel file?

We sent a final excel version of the Act Memo to carriers last week. Please contact Tara Smith at the DOI if you need a copy of this file sent to you.

#### 4.) HDHP Limit

Q: The IRS released the HRA out of pocket limits - they are slightly lower than what's included in the Rate Instructions document. The new limits are \$6,350 for individual coverage and \$12,700 for family coverage.

In the Annual Letter to FFE issuers, and in a recent FAQ (FAQ#9, released on 4/30/13), CMS noted that if the IRS-published limits were below \$6400/\$12800, carriers "would be able to review their OOPM during the resubmission window built into the QHP certification process. HHS will allow issuers to adjust other associated data elements for affected plans if necessary. For example, issuers will be permitted to modify other cost-sharing parameters in order to maintain an actuarial value consistent with the standards of 45 CFR 156.140" (the provision that defines the metal tier values, and allowable de minimis variation).

Because our rate filing deadline has not occurred, we would like carriers to make any necessary out-of-pocket adjustments prior to submitting the filing to the DOI.

# 5.) Varying Geographic Rating Areas

Q: The first line of the "Geographic Area" section in the Rate Instructions reads that there may be only one set of geographic rating factors that may not vary by product for a rate filing. Last week it was discussed that this was actually allowed per the most recent CCIIO guidance, I want to make sure this is an error in the document and the Division is not reversing their guidance.

A: The updated federal guidance, which allows states to "implement geographic rating factors that vary by plan, provided that any variation in the geographic rating factor by plan is based only on actuarially justified network cost differences for each geographic rating area," is correct.

### 6.) Forms Schedule Tab

Q: We are concerned about the requirement that the form schedule tab be completed by 5/15, as we understood all information related to the forms was needed for the June 30 filing deadline. Will the DOI accept "proxy" form numbers as placeholders on the May 15 deadline? Will we be able to amend the Form Schedule Tab on June 30 after we have completed our forms?

Per Colorado Regulation 4-2-11, Section 6, carriers are required to file an Actuarial Memorandum with each rate filing. One of the components of this Memorandum (as listed in Section 6, Part A, Item 6) is: "Policy/Rider form: a listing of all policy/rider forms impacted by the filing."

A: In requesting that carriers complete the Form Schedule Tab as part of the rate filing, the Division is simply asking carriers to enter this list of forms, completed as part of the Actuarial Memorandum, into the Forms Schedule tab. You do not have to submit actual copies of these documents until June 30, as part of your form filing. However, you should still be able to provide a Form Name, a Form Number, a Form Type, and an Action for each form/policy included in the Actuarial Memorandum. Carriers should already be completing this tab as part of a rate filing.

Q: What specific forms references are needed in the Form Schedule of the rate filing (i.e. policy forms, employer contract forms, etc.). If you can list out which forms specifically it would be very helpful. At this time our "Form" teams are still developing the forms so it may be difficult to have all the information required (form numbers, readability score, etc.)

The forms that you need to list under this tab are the forms you used in developing your rates. The Form Number is a number that you create internally and assign, and you do not need to worry about readability scores, etc. at this time. You simply need to complete the data fields in SERFF- the actual documents do not need to be submitted until June 30.

### 7.) Rate/Rule Schedule Tab

Q: Over the last year there have been many problems filling out the Rate/Rule Schedule tab as well as the Rate Review Detail information. Because these are all new plans, can you tell us which specific fields in that tab (and Rate Review Detail Pop-Up) need to be populated with data, and what the definition for each of the fields is? Additionally, if the Division could illustrate if certain fields need to align with other documents (i.e. Projected Claims and Premium in Rate Review Detail should match URRT Projected Claims and Premium) that would also be extremely helpful.

We are working collaboratively with Optumas to supplement the SERFF instructions.

## 6.) URRT

Q: In the "Supporting Documentation Tab" located in the binder, one of the documents is: Part 1-Unified Rate Review (URR) Template; on your "Required Document" It is also listed under the Supporting Docs Tab for the rate filing; where would you like the URR to go when we submit, in the binder or under the rate filing?

The URRT needs to be uploaded in two places – once in the binder and once in the rate filing. If it needs to be revised it needs to be updated in both spots. In both filings the URRT goes under the Supporting Document tab.

Q: The same question is for the Part III Actuarial Memorandum, its located in the Supporting Doc of the binder (to be an attachment) and its listed on your Required Document to go with the Rate filing under the Supporting Docs Tab, can you clarify should the memorandum go in the binder or rate filing?

Part III only needs to go in the Rate filing under supporting documents.

### **ATTESTATIONS**

Q: Can you tell me which Carrier Attestation is the final? Is it the one with the checkboxes or the other one?

The DOI is requiring two attestations:

- 1) Carrier Attestation Form this list was developed for Colorado, is on the DOI website, and has checkboxes for "Yes" responses
- 2) Program Attestations for SBE states this is the federally required list of attestations, which was renamed "State-Based Exchange Issuer Attestation: Statement of Detailed Attestation Responses." They are one and the same document- 6 pgs in length, with checkboxes for "Yes" or "No" responses.

## **HIOS**

Q: There seems to be some confusion as to what/when we need to file through HIOS versus through SERFF. Particularly, for standalone dental, CMS has indicated a HIOS deadline of May 31, as opposed to the State's updated filing deadline of June 14. My main questions are (a) are we still required to file all of the templates through HIOS in addition to the files we are submitting through SERFF and (b) do we still need to have templates filed through SERFF by May 31 even though Colorado has its own state-run exchange?

A: We will check on this and get back to you immediately.

Q: The document states on page 26 that the Part II Consumer Justification is required for all rate increases; however HHS only requires this for rate increases above the 10% threshold for rate review.

A (from CCIIO): According to our rule, ALL rate increases are always submitted to HIOS and the state DOI, our rule doesn't differentiate between exchange and non-Exchange rates. If a risk pool has even 1 rate increase of 10% or more, then the Part II consumer justification narrative must also be completed by the issuer in HIOS.

Also, if a state requires submission of the Part I URR template and Part III Actuarial Memo, then the issuer must submit to the state and CMS, even if all rates are "new".

So, when an issuer is required to submit a rate, they MUST always submit the entire risk pool to both the state and CMS, including modifications.

Q: For CO, are we only submitting rates on the SERFF website; there's been discussion that if there's a rate increase for small group, and the rates are trending quarterly, then rates need to be loaded onto HIOS; we need clarification. If that's the case, can we get guidance on the structure of uploading onto the site, and is HIOS set up for CO (ie. if additional attachments are needed similar to SERFF) and will there be instructions on where the rates will need to be loaded on the HIOS website?

HIOS has their own instruction manual for using the HIOS system. A copy of the most recent instructions can be found here:http://www.cciio.cms.gov/resources/files/hios-user-manual-2-2013.pdf. For additional assistance, please call the CMS Help Desk at 1-855-CMS-1515 or email them at CMS\_FEPS@CMS.HHS.gov.

Q: With regards to HIOS submission and upload; can you verify are we required to upload any rating information on the HIOS, per the State?

A: Beginning in 2014, all QHPs in the Exchange will be required to report any rate increase to HIOS. Plans outside of the Exchange will only be required to report increases that exceed the threshold established in each state (Colorado the amount is 10%).

# **TEMPLATES**

- Q: Quick question, have we determined if we can use a placeholder URL in the required fields?
- A: The feds are allowing this in their system as well, so there shouldn't be any issue with the SBEs doing the same.
- Q: Business rules template, we need to provide explanations; the template wouldn't allow it so we added a "note tab" worksheet, within the template.
- A: Yes, you made add explanations on the second tab of the worksheet.
- O: Service area justification, we explained any partial zip codes within the template, is that alright?
- A: The template does have a space for you to enter a brief explanation of why the service area includes partial counties. That being said, one of the justifications that we are requiring is the Partial Service Area Justification- which asks carriers to provide a more detailed explanation regarding any partial county designations. I have attached a copy of the Justification (which is also included in the Rate Instructions document), and describes the elements that must be included in the explanation; specifically: "why the partial county is necessary, non-discriminatory, and in the best interest of potential enrollees and the Exchange program" (if applicable).
- Q: A question has come up with regards to the plan benefit template- we found out that you can only load one template into the binder. DOI is requiring that we show on and off exchange plans- is the DOI's preference that we combine the on and off exchange plans in 1 template? We're concerned that when the DOI or COHBE tries to pull out the on and off exchange benefits, with them being embedded into one template you might pull an incorrect plan benefit, and it might be difficult to navigate the products/plans (if we put on and off exchange on the 1 template you would be looking at about 48 tabs in one document).

There can only be two binders – one for Small Group and one for Individual. There is a field on the Plans and Benefits Template that the carrier will mark for On Exchange, Off Exchange, or Both. This is important for several reasons – HHS is calculating the 3 R's, Exchange is calculating the CSR's and uploading to their system, and this is how the SERFF application was built.

The binder filing ties all rate filings, form filings, marketing filings, and network adequacy filings together. CCIIO and SERFF have clear instructions on these templates – all plans must be reported in one template per market. It is my understanding that this is what has been communicated in prior Stakeholder's meetings.

#### **FORMS**

- 1.) Variability
- Q: We're in need of further clarification on how we might employ variability within our upcoming Individual QHP plans submission. We anticipate 48 separate standard component IDs on the Plan and Benefits template. Apparently the SERFF binder requires that each separate standard component ID be listed. When we attach the approved SERFF filing to the binder, we have to type in the SERFF filing number, as well as the specific formfooter that goes with that standard component ID. We had hoped to file only a few policies (with variation) for the DOI forms submission for ease of your review and our response to any objections. In looking at the whole process, I'm trying to figure out the best way to accommodate variability but also be set up correctly for the COHBE binder submission.
- 2.) Uniform Application
- Q: Does the DOI plan to update the standardized application and enrollment forms that are in place now? We are working on our policy forms and were curious as to whether we should wait or update them on our own. If you are updating them, we will wait. Meanwhile would you like to have our list of items that perhaps should be addressed in the revisions?
- DOI We have been working with Connect for Health Colorado to develop individual and small group applications for use inside and outside of the Exchange. Future guidance on these documents is forthcoming.
- 3.) Spanish
- Q: We are trying to confirm the requirements for Spanish versions of the SBCs. COHBE staff has noted that they will not require SBCs in Spanish for the Exchange based on recently released CCIIO FAQ #8, Question 13. Please confirm whether the DOI is requiring SBC's in Spanish or if plans are simply required to include the standard notice in the SBC about how to access the language services (oral language services and written translations).

A: Future guidance forthcoming.

### **PEDIATRIC DENTAL**

Q: Has the State finalized their definition of "pediatric benefits?" According to the final ruling, the federal definition is "under 19 years." However, they also note that states have flexibility to vary this definition.

We have not finalized this definition, but will let you know when the decision has been made.

Q: The CMS dental templates will not be final until 5/15/13. Can you please comment on any work-arounds to this during the call on Friday?

We will be having a meeting for dental carriers next Friday, May 17.

### **OTHER**

Q: What exact time will submissions be due on the 15th? If there are system errors/validation lags not allowing carriers to submit on time can carriers take a screen shot to validate the filing was submitted, however due to system issues/validation lags it was not processed on time?

Filings are due 11:59 on May 15.

Q: Conversion plans disappear on 1/1/14, correct? Do we need to file any paperwork like the carriers that are discontinuing plans? I know we would need to give the members a 90 day notice, etc but wasn't sure if paperwork was required.

Guidance on conversion plans with be forthcoming.